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The elderly perception and views on their health -Facilitating and inhibiting factors in elderly health care in Iran: a qualitative study

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Abstract

As the proportion of older persons in the Islamic Republic of Iran is increasing and is expected to be about 10% of the total population by end of the 21st century, health policy makers are seriously concerned about what more services to offer the elderly. A qualitative research was conducted that aimed at identifying the views of the respondents relating to factors that might facilitate or inhibit the process. Seven categories were identified; concept of health, lifestyle, spiritual belief, personal and family factors, economic and social factors, health care services factor, and supportive context.

Keywords: Elderly, health related factors, elderly Iran, qualitative study

Introduction

In similarity with the global trend of an increase in the proportion of older persons, the Islamic Republic of Iran is witnessing a rapid rise in the number of the elderly. The Iranian Ministry of Health 2002 reported that in 1996, 3.97 million aged 60 and over lived in Iran, which constituted 6.6% of its total population(Abedi, & Maggs, 1997). In year 2000 it increased to 7.8%. By the end of the following decade it would have risen to 10%, and by the year 2050 it would be 21.5%.(Iran Ministry of Health, 2002). Along with these there are changes affecting family structure and roles, labor patterns, migration, as well as health care needs of the growing population. Iranian health policy makers are particularly concerned over what health care facilities to be provided, especially for the elderly persons, as at present there are no specific programs for them (Norozi, Abedi, Maddah,and Mohammadi, 2006).

Given situation, the Iranian government is aware of the social, economic and health implications affecting the elderly group of the country. Much attention is given to the topic and it is anticipated that a more appropriate health care model to cater to the needs of the elderly be developed(Iran Ministry of Health, 2002).

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An appropriate model would be something based on the real and anticipated needs of the affected group(Norozi, Abedi, Maddah,and Mohammadi, 2006). In reviewing the present situation and planning future activities, it would be necessary for the health planners to have relevant data concerning the issues.

METHODOLOGY

A qualitative study was carried out to gather data. Particular concern addressed in the study was factors that would influence the elderly health care. Thus, the purpose of the study was to investigate factors associated with elderly health care. The qualitative analysis revealed the deeper insights from the perceptual and emotional aspects of aging and is widely accepted in health and old age research (Fry & Keith, 1986). One of the approaches used by researchers is Grounded Theory, initially developed by Glaser & Strauss (1967), and has been developed and applied extensively since (Glaser, & Strauss, 1967). In this research, the method was adopted in view of the fact that very little data existed on the topic, and also because there was a need to gather current insight into the elderly's health problems. Through a systematic approach to data collection and analysis of social processes within human interactions the researcher aimed to discover the concepts, categories and themes related to the topic. There might be a theory emerging from the empirical data that could explain the underlying social processes and structures (Glaser, & Strauss, 1967).

Sampling was purposive, in that informative cases were actively located and sought during the research process (theoretical sampling) (Burns & Grove, 2008). Fifteen elderly women and men 60 years and above were interviewed in-depth. Four persons who were spouses of the respondents were also interviewed. To represent the health authority, three health care providers and four health care managers in Isfahan were interviewed also. They were included to provide views of those having the experience in dealing with the health care of the elderly. Three methods of data collection were used; unstructured interviews, observation and focus group discussions. All interviews were audio-recorded and transcribed (Glaser, & Strauss, 1967).

Thus data comprised of transcripts from tapes, field notes and analytic and process memos. The constant comparison method was used to discover the categories from the data. Three coding

processes, i.e. open, axial and selective coding were applied in data analysis.(Strauss & Corbin 1998). Assurance of confidentiality and anonymity in the research process and reporting was given to all respondents in compliance to the ethical requirement of the study.

FINDINGS

Seven categories were identified; (i) concept of health (ii) lifestyles (iii) spiritual belief (iv) personal and family factors (v) economic and social factors (vi) health care services factor, and (vii) supportive context. These will be briefly defined, described and illustrated in turn.

1. Concept of Health

A range of meanings were associated with the term 'health'. From the disease aspect, it was a kind of "freedom from disease". Conveying the emotional side of respondents were expressions like "being content", "being cheerful", "not being alone " and " having a good caregiver" . Meanings associated with the spiritual needs were seen in the respondents responses as "being free of need of God's creatures (which means being in need of God)".

Evidently there were expressions denoting the physical ability, i.e. "being active", "having the ability to work", and "having good support and economical procurement". Although them responses were expressed as single statements, the idea of 'health' actually incorporated various aspects of the person. Being independent, active, having a family and getting the social and economic support all contributed to the person's health and wellbeing. These are manifested in their attitudes and behaviors. An example illustrates this point:*"At this stage of life I believe that disease is one part of our life. If I have some support I think I'm healthy. I can be active and hopeful. To be healthy we should satisfy God and get his help. That's why I always give food and money to the needy.*

I pray to God and try to do some thing for others. If I do this God would support me

too"(participant 3)

2. Lifestyle

This category includes all behaviors that relate to their nutrition, physical activity, adherence to medications, and compliance to health recommendations. Lifestyle as a direct agent is influential in promoting the level of health in the elderly. Most respondents feel that their day to- day activity, nutrition and health care practices contribute to their health conditions. Those who said they had a good level of health thought that it was not necessary to do anything different. They did not feel they were vulnerable to any health risks, and therefore there was no reason to promote themselves to a better level of health. Any change in the respondents' lifestyle was likely to be influenced by factors that include their level of knowledge, economic status, cultural beliefs, present illness, religious beliefs and perception about health. These factors could either act to facilitate or inhibit their health status.

Another important factor was the extent of relatives' control over the individuals

"I know how to be healthy,- eat good things, for sure. But when I don't have enough money I can only eat something just not to be starved" (participant 10)

"After all is said and done, we are Moslems…By tolerating pain and having a life of hardship I shall lead to a good end, I mean in the other world. Because of this it is not important for me to change my conditions" (participant 3)

3. Spiritual Beliefs

Spiritual beliefs include dependence on the occult power and performing religious duty. Spiritual beliefs affected the elderly health care either positively or negatively. If they could use them to counter negative psychic effects of ageing, the elderly could increased their satisfaction of life. On the other hand the beliefs could lead to passive reactions if they were not directed at overcoming their physical constraints.

"I believe my life evolves during this period. I gain so many things, I have so many abilities… I should use my abilities to promote my life and give my experiences to others too (participant 7)".

"I think our conditions such as disease, problems and so on in old age are retributions of our actions when we were young. We have to respond to our actions - everyone is responsible for his own actions. Now is too late …we cannot do anything but to accept these conditions (participant 12)".

4. Personal and Family Factors

Personal and family factors are intertwined. Attitudes toward lifestyle, whether positive or negative, and the willingness to adopt behavioral change were partly determined by family support in coping with the aged. These categories are further divided into three subcategories - adaptation mechanism, self-confidence, and family role in care. Most respondents resort to the use of emotive-based mechanism. They talked to family members and friends to gain their affective supports. They also attempted to focus on minor tasks so that they could forget their personal and health problems. However, these mechanisms had temporary effect and the problems remained.

The choice of adaptive mechanism depended on their knowledge and awareness about the needs of the elderly. Most influential was the individual's self-confidence in their ability in initiating and sustaining desired lifestyle changes. Yet despite their awareness and self confidence, very little attention was given to elderly care. Explained by the following respondent, the reasons relate to personal problems:

"After retiring I faced many problems. Although I have good experiences and abilities I have to stay at home. Everyday I go to the park to visit my friends and talk with them. This way I can forget my problems" (participant 17).

"…last year one of my relatives told to his mother that he was going to take her to her relative house. They took, yes but only to release her at a charity old people's home. They never visited since then" (participant 11).

5. Economic and Social Factors

This category includes all issues related to the elderly's various social problems arising from economic, and other societal problems. This appeared to be the most influential factor in elderly health care. Lack of financial and

social support hindered most of the old people from complying with their medical treatment and adopting healthy behavior. The following expressions relate to this category:

"I suffer from the pain in my knee, I need medical care but I cannot go to get medical care because I don't have enough money, no insurance and financial support"(participant 1).

"…there is not any special place for the elderly in our city such as a cultural or social center…concerning transportation services in the city - there is no facilities for old people there. Because of this I have to spend my time at home and waste my time and life. I feel bad…I wait for dying" (participant 2).

6. Health Care Services Factors

Health care services include health planning related factors, human resources issues and limitations of health care system. Under the country's program of elderly health, care of the elderly is the responsibility of the health care network in Iran. Present situations reveal that the system is incomprehensive, there is lack of intersectoral cooperation, lack of knowledge on elderly's needs, management and administrative problems in health care centers, multiple issues related to accessibility, professionals, and human resources.

As voiced by twp respondents:

"I came to this center (health center) because I have several problems. When after they checked my blood pressure they told me that they could not do anything for me. They told me I should go to a private clinics as there is not any specialist in this center to attend to my problems" (participant).

"…there isn't any health care center near my house. To come to this center I have to pay too much money and I have to come with one of my child because I cannot come here alone. So I cannot come here if I need to and I cannot come regularly"(participant 5).

From one of the health care managers these statements were said: *"To provide health care for the elderly we need sufficient and trained staff. In health care centers we don't have facilities to provide care for the elderly. There is not enough staff and because of some limitations in hiring human resources our health care workers have several tasks to do, and because of this they attend according to priorities. They don't see old people as a priority".*

7. Supportive Context

This category involves issues in supportive contexts with the properties in terms of respect, love, kindness, pecuniary support, and information and knowledge. Old people received three kinds of supports - affective, instrumental and informational supports. More often they received affective support through family members. This domain of support not only provided comfort but was able to reduce the respondent's stress and anxiety. These led to their having a sense of being mentally and emotionally healthy. Although this factor could stimulate the elderly to adopt a healthy lifestyle it was not sufficient and influential enough. Most respondents' views stressed on the need for instrumental support in the form of pecuniary needs, and health and treatment care from the family and society. Among barriers for instrumental support were factors related to economic, family and society, insurance services, accessibility to health care team and services, organization. Informational support was another category.

Respondents expressed their feelings about the issue:

"…in this age of new generations every thing are changed. They don't show respect for grandmothers and grandfathers. My wife passed away one year ago, and I am alone…my son don't pay attention to me. Till today it's one year now that my son don't open my house's door (visit me). It isn't important for them what happen to me. I think it is due to their problems - they have so many problems in their life…"(participant 11).

As one of the managers said:

"Conditions of insurance for almost 50% of the elderly is not clear …almost four million of them don't have financial provision…"(participant 18)

DISCUSSION

The analyses have led the researcher to identify seven major categories that were influential in elderly health care; concept of health, lifestyle, spiritual believes, personal and family factors, economical and social factors, health care services factors, and supportive context.

The elderly's concept about health was found to be key factors and was similar to the findings from wherein it was shown that the individual's definition of health strongly influence their health behaviors (Pullen, Walker & Fiandt, 2001; Mahasneh, 2001).

In this study it was shown spiritual beliefs had a supportive role in effecting mental health, yet the factor tended to play a negative role due to the social and cultural conditions in Iran. Rather it acted as a barrier to better life style for the elderly. Similar findings were shown in a study (Rowe & Allen 2004). Much remained lacking at the personal, family and societal levels. Despite having the self confidence and the ability to adopt psychological and behavioral mechanisms to deal with limiting situations the individuals could not overcome the lack of facilities and efficiency at the organizational and larger economic levels. Shortage of health staff and related resources were beyond their understanding and control. While the elderly were in dire need of information and knowledge the existing facilities were not conducive for them to think more about promoting their health. Much was to be expected if they could access to places where they could increase their awareness through information and knowledge. As illustrated by some studies, problem-based adaptation mechanisms were used by individuals who had a higher level of information and awareness, hence leading to their having more interest to change their lifestyle (Pat, & Mapp 1999: Speck & Harrell, 2003: Ravanipour; Salehi; Taleghani, & Abedi, 2008).

In conclusion, this qualitative study has enabled the collection of in-depth data on the elderly's perception and views on their health and the factors that influence their health care. The data is being further analyzed to explore emerging theory. So far, much has been gained from both the recipients and provider of elderly health care. The findings would be very useful to Iran health planners' effort to improve the quality of life of its elderly population (Salarvand, Abedi, & Karimollahi, 2008).

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